



Medicare Part D Prescription Plan Worksheet

Toll Free: 1-877-801-0044 Local: 1-931-379-2927

FAX: 931-379-2685 or Email: sctn.ship@sctdd.org

If you would like to have a free 2024 Part D Insurance Plan or Medicare Advantage Plan Comparison done to check your prescription Costs, fill out both sides of this form. We cannot do a comparison without all of this information. Please complete and return this form by Nov 20, 2023.

Mail to: SHIP/SMP, 101 Sam Watkins Blvd, Mt Pleasant, TN 38474; FAX: 931-379-2685 or Email: sctn.ship@sctdd.org

Or drop off at the Volunteer Services office at 1222 Trotwood Ave, Building A on the hospital campus in Columbia.

To request an in person appointment fill in the location of your local Senior Citizens Center or Maury Regional Example: Maury County Senior Center. Completed forms must be returned prior to appointments being made.

Name: _____ Date of Birth: ____/____/____ [Please provide your name as it appears on your Medicare Card]

Address: _____ [Please provide the address and zip code you have on file with Social Security]

City: _____ State: TN Zip: _____

Phone: _____ County: _____

SSN Number: _____

Email address: _____

What is your Medicare Number? _____

What is your effective Date for Part A? _____ Part B? _____

MEDICARE HEALTH INSURANCE logo and sample card information for JOHN L SMITH, Medicare Number 1E64-TE5-MK72, with Part A and B coverage starting 03-03-2016.

Searches will be done using MyMedicare.gov. If you have a MyMedicare.gov Account already... we need your

User Name: _____ Password: _____

If you do not have an account, we will make one for you and mail your account info to you with your comparison. You will receive a letter from CMS..welcoming you to MyMedicare.gov a few days after the account is created. If you cancel the account we will Not be able to do the comparison for you.

Do you currently have insurance coverage for Prescriptions ___ Yes ___ No If yes, check any that apply:

___ Medicare Part D Plan (name) _____

___ Medicare Advantage Plan (name) _____

- ___ Medicaid ___ Employer/Union Group Health Plan ___ Federal Employee Health Benefit Plan
___ TRICARE for Life ___ Veterans Administration ___ Medigap/Medicare Supplement

___ Other _____ (retirement, private, etc.)

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